

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-001478

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 529 STATE FILE NUMBER

FILED FEB 8 1963

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived: If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph Hospital		c. CITY OR TOWN Independence	
Length of stay in lb 12 Hours		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Kansas City, Missouri		d. STREET ADDRESS (If outside, give location) 3413 Vermont	
Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jack Middle Wesley Last Call		4. DATE OF DEATH Month Jan Day 25 Year 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-22-1923
9. AGE (last birthday) 39		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Radio Anouncer		10b. KIND OF BUSINESS OR INDUSTRY KCMK FM Radio	
11. BIRTHPLACE (City and state or country) Trenton, Missouri		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Bert Call		13b. MOTHER'S MAIDEN NAME Rose McLaughlin	
14. NAME OF HUSBAND OR WIFE Anna Bell Call		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW 2	
16. SOCIAL SECURITY NO. [REDACTED]		17. INFORMANT Address Mrs. Anna B. Call 3413 Vermont Indep. Mo.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Subclaval Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Subcarculation	
20c. TIME OF INJURY Hour 12463 Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) St. Joseph Hospital		20f. CITY, TOWN, OR LOCATION Independence COUNTY Jackson STATE Miss	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Geo. C. Carson		22b. ADDRESS 6620 Brookfield Ave	
22c. DATE SIGNED 1-26-63			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Jan 28, 1963	23c. NAME OF CEMETERY OR CREMATORY Mt. Washington Cemetery	
23d. LOCATION (City, town, or county) Independence, Missouri		(State)	
24. FUNERAL DIRECTOR Geo. C. Carson & Sons		25. DATE RECD. BY LOCAL REG. 1-28-63	
ADDRESS Independence, Mo.		26. REGISTRAR'S SIGNATURE Reeth Long	

DOCUMENT

George C. Kealhofer MEDICAL CERTIFICATION BY AFFIDAVIT OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK
OR
TYPEWRITER RIBBON

VS 300
Rev. 4/59

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11 **120**

12 **65-3**

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Marshall C. Blackwell

Licensed Embalmer No. 4713

P. O. Address Raytown, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.